VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

NARC.1
FORM#18
C: 12.14

Agency of Human Services

~Long Acting Narcotics~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Name: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy Phone: _____Pharmacy Fax: _____

1. Drug/Dose/Frequency and Length of Therapy:
   _____
   _____
2. Brand Name or Generic Equivalent
3. Diagnosis or Indication for Use:
   _____
   _____
4. Has the member previously tried any of the following preferred medications?

Check all that apply:	***Response, check all that apply***
Fentanyl Patches	side-effect non-response allergy
Methadone	side-effect non-response allergy
Morphine Sulfate CR 12 Hr Tablet	side-effect non-response allergy

For tramadol products, has the member previously tried the following preferred medication?

Check if applicable:	***Response, check all that apply:***
Tramadol immediate release	side-effect non-response allergy

Is this an initial request or a renewal request? Initial Renewal

Other Information/ Comments:_____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature:_____ **Date of request:**_____

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